STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155711	A. BUILDING 00 B. WING	09/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND MANOR HEALTHCARE	2926 NORTH CAPITOL AVENUE INDIANAPOLIS, IN46208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00095694 and Complaint IN00095779. Complaint IN00095694 unsubstantiated due to lack of evidence. Complaint IN00095779 substantiated no deficiencies related to the allegations are cited. Survey dates: September 12, 13, 14, 15, 16, 2011 Facility number 000567 Provider number: 155711 AIM number: 100289560 Survey team: Connie Landman RN TC Diana Zgonc RN Christi Davidson RN Courtney Hamilton RN Census bed type: SNF: 3 NF: 14 SNF/NF: 26 Total: 43 Census payor type:	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Medicare: 3 Medicaid: 40 Total: 43 Sample: 25 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 9/21/11 Cathy Emswiller RN			

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F0156 SS=E	The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;			

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	A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.			

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	The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on interview the facility failed to ensure Medicare discharge letters were sent to resident's whose Medicare benefits had been exhausted for 3 of 3 residents reviewed for Medicare discharge letters in a Stage 2 Sample of 25 (Resident # 36, # 27 and # 55). Findings include: During an interview with the Administrator on 9/15/11 at 2:00 P.M., the Medicare discharge records were requested for review. He indicated at that time the letters had not been done. He stated, "We didn't realize it until our mock survey they were not being completed." 3.1-4(f)(3)	F0156	All residents have the potential to be affected. Residents will be reviewed during weekly Medicare/Therapy meeting to determine if a change in service is anticipated and if a Medicare discharge notice is required. Identified residents will have the appropriate Medicare Discharge letter selected and produced by the Social Services Director. Social Services Director will notify resident with letter and appropriate signatory of understanding. MDS and Social Services Director are responsible. Administrator, Executive Director, and DON will monitor for compliance. Compliance will be evaluated weekly 3x and then quarterly 3x by QA. Completed 9/26/11 and on-going.	09/26/2011

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F0224 SS=G	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on observation, record review and interview the facility failed to ensure a resident was not kept from harm while receiving pericare resulting in the resident experiencing pain and discomfort. This affected 1 of 25 residents reviewed for pericare in a stage 2 sample of 25. (Resident #26) 1. Resident #26's record was reviewed on 09/14/11 at 9:25 A.M.. Diagnoses included but were not limited to left above the knee amputation, debility, CVA (cerebrovascular accident), HTN (hypertension), dementia with agitation, and psychosis. A current Minimum Data Set (MDS) dated 05/17/11, indicated resident #26 had a BIMS (brief interview for mental status) score of 6 (severe cognitive impairment), did not ambulate, and was totally dependent on staff for locomotion, dressing, eating, toileting, personal hygiene and bed mobility. Resident #26 had ROM	F0224	All residents have the potential to be affected. Nursing staff has been re-trained on provision of peri-care with clear emphasis n identifying when care becomes abusive. One on One peri-care in-service conducted and repeated to define when to stop care admin and acknowledge resident comfort. Abuse in-service conducted to more clearly define when and how care can become abusive. Care (routine and peri) is monitored by nurses. Skills forms are available for use during care observation to identify areas of re-training and redirection. Charge nurses are responsible for observing/training during daily care. Skills performances monitoring care/abuse will be reviewed monthly 3x and hen quarterly 3x in QA. Peri-care in-service completed 9/23/2011. Abuse/Neglect in-service completed 9/23/1011. Charge nurses are responsible. DON will monitor on rounds and review of skills forms.Completed 9/23/11 and ongoing.	09/23/2011

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	(range of motion) limitation on both sides of his upper and lower extremities. A current care plan dated 08/31/11, indicated resident #26 had a Foley catheter and was dependent for ADL's (activities of daily living), bathing, dressing, and grooming. The care plan indicated the resident was incontinent of bowel. The care plan also indicated resident #26 had contractures of his left hand and left elbow and a rectal fistula. During an observation of pericare on 09/14/11 at 10:40 A.M., CNA #2, pulled the covers off of Resident #26. Resident was nude under the covers. CNA #2 roughly grabbed the resident's testicles and started roughly washing them using a wet soapy washcloth. Resident #26's testicles were very red and excoriated. As CNA #2 washed the testicles, the resident started yelling, "...ouch your hurting my balls...stop...that hurts." CNA #2 responded by saying, "sorry, but I gotta clean this". The CNA then grabbed Resident #26's penis and again started roughly washing the penis and the Foley catheter. The resident yelled out, " stop... ouch your hurting my peter...ouch!". The CNA			

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	again responded by saying "sorry, I have got to clean this". The CNA did not stop rubbing the resident nor did she reduce the amount of force she was using when the resident stated he was in pain. CNA #2 then rolled Resident #26 over. The resident had a bowel movement and some stool was sitting in his rectal fistula. His buttocks were excoriated. CNA #2 used a dry towel and started wiping Resident #26's buttocks and rectal area. The resident started yelling, "ouch that hurts...you know I have hemorrhoids stop..ouch...ouch...my hemorrhoids!". CNA #2 responded by saying, "you don't have hemorrhoids you have a wound..." There was stool visible in the rectal fistula. Again, the CNA did not reduce the amount of rubbing or the amount of force she was using when the resident stated he was in pain. The CNA turned the resident over on to his back. He was completely exposed. The resident stated, "I'm cold, cover me up." The CNA stated, "Ill cover you up when I'm finished with you." The CNA repositioned Resident #26 and then grabbed a washcloth to place in his contracted left hand. CNA #2 told the resident to relax and started to push the washcloth into the resident's hand. The resident began to yell, "you are killing me....ouch ouch ouch			

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	ouch...stop.... you are killing me...stop!" The CNA told the resident if he relaxed it wouldn't hurt as much as she continued to push the washcloth into his hand. The resident yelled again, "...stop...you know I have 'thritis (arthritis)...ouch ouch..." The resident tried to reach up with his other hand and stop the CNA but could not reach her. The CNA did not stop until the washcloth was in his hand. The resident indicated his hand hurt, and the CNA responded, "its going to hurt for a little bit." The CNA left the resident nude and then covered the resident up and left the room. An interview with CNA #2 on 09/14/11 at 12:15 P.M., indicated she had gone back into the room and place barrier cream on the resident's testicles. The CNA indicated, the resident always screams like that during pericare. She indicated, "...I just tell him to relax, like I did when I was putting the washcloth in his hand..." A current undated facility policy titled, "Abuse and Neglect' provided by the Executive Director on 09/14/11 at 12:23 P.M., indicated, "Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical			

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	harm, pain or mental anguish..." A current undated facility policy title, "Abuse Protection Policy" provided by the Executive Director on 09/14/11 at 12:23 P.M., indicated "It is the policy of this facility to protect residents from all abusive acts..." Procedure: 7. Any staff member, who intentionally abuses a resident or permits to exist an abusive situation which results in the abuse of a resident, is subject to immediate dismissal. Any staff member suspected of abuse will be suspected pending the investigation into the allegation..." 3.1-28(e)			
F0241 SS=G	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review and interview, the facility failed to ensure resident's dignity was preserved during pericare, while in the restroom and in the dining room during meal times. This affected 3 of 25 residents reviewed for dignity in stage 2 sample of 25. (Residents #26, 29, 69) Findings include:	F0241	All residents have the potential to be affected.Same as in F 224. Nursing staff has been re-trained on provision of peri-care with clear emphasis n identifying when care becomes abusive. One on One peri-care in-service conducted and repeated to define when to stop care admin and acknowledge resident comfort.	09/26/2011

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	1. Resident #26's record was reviewed on 09/14/11 at 9:25 A.M.. Diagnoses included but were not limited to left above the knee amputation, debility, CVA (stroke), HTN (hypertension), dementia with agitation, and psychosis. A current Minimum Data Set (MDS) dated 05/17/11, indicated resident had a BIMS score of 6, did not ambulate, and was totally dependent on staff for locomotion, dressing, eating, toileting, personal hygiene and bed mobility. Resident had ROM (range of motion) limitation on both sides of his upper and lower extremities. A current care plan dated 08/31/11, indicated resident had a Foley catheter and was dependent for ADL's (activities of daily living), bathing, dressing, and grooming. The care plan indicated the resident was incontinent of bowel. The care plan also indicated resident had contractures of his left hand and left elbow and a rectal fistula. During an observation of pericare on 09/14/11 at 10:40 A.M., CNA #2, pulled the covers off of Resident #26. Resident was nude under the covers. CNA #2 roughly grabbed the resident's testicles and started roughly washing them using a wet soapy washcloth. Resident #26's testicles were very red and excoriated. As CNA #2 washed the testicles, the resident started yelling, "...ouch your hurting my balls...stop...that hurts." CNA #2 responded by saying, "sorry, but I gotta clean this". The CNA then grabbed Resident #26's penis and again started roughly washing the penis and the Foley catheter. The resident yelled out, " stop... ouch your hurting my peter...ouch!". The CNA again responded by		Abuse in-service conducted to more clearly define when and how care can become abusive. Care (routine and peri) is monitored by nurses. Skills forms are available for use during care observation to identify areas of re-training and redirection. Charge nurses are responsible for observing/training during daily care. Skills performances monitoring care/abuse will be reviewed monthly 3x and hen quarterly 3x in QA. Peri-care in-service completed 9/23/2011. Abuse/Neglect in-service completed 9/23/1011. Charge nurses are responsible. DON will monitor on rounds and review of skills forms.Completed 9/23/11 and ongoing. Dignity inservice done 9/23/11. Additionally a “Care Instruction Sheet” has been completed on each resident to include indentified specific needs once staff aware. Nurse aides are aware of the location of these sheets and the purpose. They are also aware that they can add info re: the resident also. Resident interviews have been previously conducted and will continue monthly to aid in identifying needs/concerns. Identified areas will be addressed on “Care Instruction Sheet” and/or individual care plans. All department heads are responsible for gathering information and individual departments are responsible for implementing changes as	

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	saying "sorry, I have got to clean this". The CNA did not stop rubbing the resident nor did she reduce the amount of force she was using when the resident stated he was in pain. CNA #2 then rolled Resident #26 over. The resident had a bowel movement and some stool was sitting in his rectal fistula. His buttocks were excoriated. CNA #2 used a dry towel and started wiping Resident #26's buttocks and rectal area. The resident started yelling, "ouch that hurts...you know I have hemorrhoids stop..ouch...ouch...my hemorrhoids!". CNA #2 responded by saying, "you don't have hemorrhoids you have a wound..." There was stool visible in the rectal fistula. Again, the CNA did not reduce the amount of rubbing or the amount of force she was using when the resident stated he was in pain. The CNA turned the resident over on to his back. He was completely exposed. The resident stated, "I'm cold, cover me up." The CNA stated, "Ill cover you up when I'm finished with you." The CNA repositioned Resident #26 and then grabbed a washcloth to place in his contracted left hand. CNA #2 told the resident to relax and started to push the washcloth into the resident's hand. The resident began to yell, "you are killing me....ouch ouch ouch ouch...stop.... you are killing me...stop!" The CNA told the resident if he relaxed it wouldn't hurt as much as she continued to push the washcloth into his hand. The resident yelled again, "...stop...you know I have 'thritis (arthritis)...ouch ouch..." The resident tried to reach up with his other hand and stop the CNA but could not reach her. The CNA did not stop until the washcloth was in his hand. The resident indicated his hand hurt, and the CNA responded, "its going to hurt for a little bit." The CNA then covered the resident up and left the room.		indentified. Executive Director, Administrator, DON will monitor on review and walking rounds. Findings and recommendations will be reviewed monthly 3x and then quarterly 3x in QA. Completed 9/26/11 and on-going.	

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	An interview with CNA #2 on 09/14/11 at 12:15 P.M., indicated she had gone back into the room and place barrier cream on the resident's testicles. The CNA indicated, the resident always screams like that during pericare. She indicated, "...I just tell him to relax, like I did when I was putting the washcloth in his hand..." 2. The record for Resident #69 was reviewed on 09/14/11 at 8:50 a.m. Diagnoses included, but were not limited to bipolar disorder, auditory hallucinations, high cholesterol, anxiety, agitation, schizoaffective disorder, uncontrolled diabetes mellitus type II and legally blind in the right eye. An admission Minimum Data Set (MDS) Assessment dated 08/25/11, indicated Resident #69 had severely impaired vision. The MDS indicated Resident #69 was able to recall all three words given in assessment and was oriented to year, month and day of the week. A nutritional assessment dated 08/19/11 indicated, "...Feeds self in MDR [main dining room]...." A Social Service Progress Note dated 08/24/11 at 17:38 (5:38 p.m.) indicated, "...States that she is			

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spoken to rudely...Became tearful at one point...verbal about...likes and dislikes...."

A care plan dated 08/25/11 indicated, "...States...thoughts...would be better off dead due to living in a new situation. Has no plan at this time...Will make no attempt to harm self...Interventions...Attempt to be available to resident when she wants to talk...Encourage to continue to do the things...is able to do and praise efforts...."

During an interview on 09/12/11 at 1:57 p.m., Resident #69 indicated, "They don't always know what to do with me, like at the table." Resident #69 indicated she did not want help in the dining room during meal times with opening milk or juice cartons and opening utensils. Resident #69 indicated, "They want to open it up, and I say no I can do this."

During an observation and interview on 09/13/11 at 12:30 p.m., Resident #69 was eating lunch. Resident #69 indicated the staff had opened her milk for her. She indicated she will continue to remind them she does not need help.

During an interview on 09/15/11 at 10:21 a.m., Resident #69 indicated this morning at breakfast she was having difficulty opening the milk carton and another resident brought it to staff attention. Resident #69 indicated a staff member came over and opened the milk carton while she was in the process of doing it. Resident #69 indicated, "I don't know what to do about it. I don't know if they have ever had a person that can't see very well." Resident #69 indicated she feels "helpless." Resident #69 indicated, "I didn't know what to

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HIGHLAND MANOR HEALTHCARE	2926 NORTH CAPITOL AVENUE INDIANAPOLIS, IN46208

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	say or what to do." During an interview on 09/15/11 at 2:52 p.m., CNA #3 indicated she has seen other staff members set-up Resident #69's tray in the main dining room. "They are so used to just opening things up." 3. The record for Resident # 29 was reviewed on 9/15/11 at 9:05 A.M. Diagnoses for Resident # 29 included but were not limited to Amyotrophic Lateral Sclerosis (ALS), Acute Urinary Retention, Diabetes, Hypertension, Dementia, Depression, Benign Prostatic Hypertrophy, pain, Anxiety, bladder obstruction, Coronary Artery Disease, Neuropathy, Constipation and Hyperlipidemia. Review of the resident's annual MDS (Minimum Data Set) assessment dated 6/30/11 indicated the resident was totally dependent on staff for dressing, eating, toileting and personal hygiene. A current Plan of Care originally dated 4/8/11 indicated a Fall Risk due to decreased inability to use his upper extremities because of a diagnoses of ALS. A Social Service note dated 6/29/11 indicated the resident had no use of his arms and hands and is totally dependent on staff for his care.			

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	During an interview with the resident on 9/12/11 at 11:45 A.M., he indicated the staff did not treat him with dignity and respect, they come in and sit me on the toilet, then leave and don't come back. "I have to holler to get someones attention because they don't give me the pull cord to the call light and they know I can't reach it." Observation at that time of the resident and the resident's bathroom indicated he was unable to move his left arm due to a diagnoses of ALS and the call light cord in the bathroom was on the left side. During an interview with the Director of Nursing on 9/14/11 at 4:30 P.M., she indicated the resident was not supposed to be left alone in the bathroom. 3.1-3(t)			

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F0279 SS=E	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to ensure care plans were developed and followed for 4 of 25 residents reviewed in a Stage 2 sample of 25 (Residents #6, #30, #71, and #69). Findings include: 1. The record for Resident #6 was reviewed on 9/15/11 at 9:40 A.M. Current diagnoses included, but were not limited to, splenic rupture, GERD (gastroesophageal reflux disease), esophagitus, anemia of chronic disease, depression, right hip internally rotated, shortened, history of right hip surgery,insomnia, muscle spasms,dysphagia, poor intake, history of anoxic brain injury, and DVT (deep vein thrombosis).	F0279	All residents have the potential to be affected. Care plans have been reviewed for all residents with participation of all care givers to identify needs/concerns/problems in an effort to have a complete and accurate POC for each resident. Changes in MD orders are reviewed daily by DON for problems requiring update on POC for specified residents. MDS coordinator will initiate care plan on admission identifying two problems then gernerate additional from triggered items on MDS. Information from resident interviews is also incorporated in the POC as indicated. All disciplines are responsible. DON monitors updates during review of new MD orders daily and weekly	09/26/2011

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	The current recapitulation of physician's orders indicated a treatment, dated 6/18/11, of Santyl to the eschar on the right heel was to be applied daily. Another order, dated 8/12/11 indicated Warfarin Sodium 7.5 mg (milligrams) was to be given daily at 5:00 P.M. The original care plans were dated 6/3/11, and they were last reviewed on 7/28/11. The record lacked a care plan for an area of black eschar, 4.6 cm (centimeters) by 3.0 cm present on admission, 6/3/11, and currently measured as 2.0 by 2.0 cm. noted on the weekly skin report sheets. The record also lacked a care plan for the use of the Warfarin Sodium - which is a blood thinner. 2. The record for Resident #30 was reviewed on 9 /14/11 at 9:05 A.M. Current diagnoses included, but were not limited to, traumatic subdural hematoma, schizophrenia, atony of bladder, MR (mental retardation). HTN (hypertension), constipation, hypothyroidism, dyslipidemia, CAD (coronary artery disease). The current recapitulation of physician's orders indicated Resident #30 was to receive 100 ml (milliliters) of water as a flush through the G/T (gastrostomy tube) 3 times a day. The record lacked a care plan for Resident #30's G/T (gastrostomy tube) care, or flushes by G/T.		in care plan conferences with the individual residents. Review monthly 3x then quarterly 3x in QA. Completed 9/26/11 and on-going.	

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	During an interview with LPN #4 on 9/15/11 at 2:25 P.M., she indicated there was no care plan for her G/T with the rest of the care plans. 3. The record for Resident #71 was reviewed on 9/15/11 at 12:30 P.M. Current diagnoses included, but were not limited to, nephrectomy, osteomylitis lower spine, HTN, DM (Diabetes Mellitus), left upper extremity fistula. A care plan, dated 8/17/11, indicated a problem of "Dialysis". Interventions included, but were not limited to, assess weight pre/post dialysis, assess B/P (blood pressure), and communicate with dialysis for needed documentation regarding run. The Nurses Notes indicated Resident #71 went to dialysis on 8/30/11, 9/1/11, 9/8/11, 9/10/11, 9/13/11 and 9/15/11. The record lacked documentation of pre/post dialysis weights, B/Ps, documentation from the dialysis center, or that he had returned from dialysis. During an interview with LPN #4 on 9/16/11 at 10:10 A.M., she indicated the dialysis center had never sent any paper work back with him. 4. The record for Resident #69 was reviewed on 09/14/11 at 8:50 a.m. Diagnoses included, but were not limited to bipolar disorder, auditory hallucinations, high cholesterol, anxiety, agitation, schizoaffective disorder, uncontrolled diabetes			

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	mellitus type II and legally blind in the right eye. An admission Minimum Data Set (MDS) Assessment dated 08/25/11, indicated Resident #69 had severely impaired vision. The MDS indicated Resident #69 was able to recall all three words given in assessment and was oriented to year, month and day of the week. The MDS indicated Resident #69 was frequently incontinent of urine and a toileting program had not been attempted since admission to the facility. The MDS indicated Resident #69 was receiving a diuretic. An admission assessment dated 08/19/11 indicated Resident #69 was not continent of bowel or bladder. The admission assessment indicated this resident required supervision for toileting. An assessment for bowel and bladder training dated 08/19/11 indicated Resident #69, "...Occasionally Incontinent [sic]...Continent of bowel...." A current recapitulation with a current physician's order dated 08/19/11 indicated, "...Furosemide 80 mg [water pill] tablet give 1 tablet orally once a day...." A current Medication Administration Record (MAR) dated for September 2011, indicated, Resident #69 received Furosemide 80 mg at 9:00 a.m. everyday 09/01/11 through 09/15/11. A nurses note dated 08/20/11 at 1:00 p.m., indicated Resident #69 wears a brief and was incontinent at times.			

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	A nurses note dated 08/24/11 at 12:00 p.m., indicated Resident #69 voided while in the main dining room and was assisted with pericare and changing clothes. A nurses note dated 09/02/11, untimed, indicated Resident #69 has episodes of incontinence. During an observation on 09/12/2011 at 02:06 p.m., Resident #69 pants were wet in the middle of her thighs. Resident #69 was in a bedside chair in resident's room during initial interview. During an observation 09/13/11 at 1:12 p.m., Resident #69 was leaving the dining room walking down the hall with a walker. The back of the resident's shorts were wet over buttocks area. A Social Service Progress note dated 09/13/11 at 17:41 (5:41 p.m.) indicated, "Very tearful immediately after lunch...had apparently become incontinent after eating and was quite distraught...." On 09/14/11 at 2:45 p.m., care plans, activity notes and social service notes were requested from the Social Service Director (SSD). Care plans for Resident #69 were provided by the SSD on 09/14/11 at 4:30 p.m. The most recent care plans for Resident #69 were dated 09/01/11 and were reviewed on 09/15/11 at 12:50 p.m. The record lacked documentation of an incontinence care plan.			

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During an interview on 09/15/11 at 10:28 a.m., Resident #69 indicated there was not a toileting schedule. Resident #69 indicated, "I 'm getting a water pill in the evening."

During an interview on 09/15/11 at 12:57 p.m., LPN #5 indicated Resident #69 was not on a toileting program. LPN #5 indicated the staff encouraged the resident to toilet before and after meals. LPN #5 indicated, Resident #69 likes to sit down front and doesn't always wear a brief. LPN #5 indicated Resident #69 gets embarrassed if has an incontinent episode.

During an interview on 09/15/11 at 2:52 p.m., CNA #3 indicated the resident was admitted to the facility with personal briefs size 2X (extra large) and wore two at a time. CNA #3 indicated Resident #69 goes "a lot" when incontinent. CNA #3 indicated Resident #69 is out of personal briefs; therefore, the facility depends are being used and do not fit properly. CNA #3 indicated the Director of Nursing (DoN) was informed.

A facility policy provided by the DoN on 09/16/11 at 8:30 a.m., titled, "Care Plan," indicated, "Policy: It is the policy of the facility to create, review and update a plan of care that addresses the needs and problems,specific to the resident Procedure: *Initiate a plan of care on admission *update problems as they occur *include triggered RAPs [Resident Assessment Protocol] from the MDS [Minimum Data Set] that are determined to require a care plan *formulate a measurable goal specific to the identified problem/need *formulate related approaches to reach the goal *date the initial problem/need *date the reviews as done and

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	all disciplines sign as participating *identify the responsible disciplines involved for each approach *review the care plan monthly, quarterly or as significant changes occur *invite the resident/family to attend (if resident/family unable to attend, review the care plan by phone or in person if so desired) *update care plan dates and problems each review if applicable *maintain the active care plan throughout the admission Responsible disciplines: Nursing, MDS, Social Service, Actives Dietary, Therapies." 3.1-35(a)			
F0282 SS=G	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview and record review the facility failed to follow physician's orders regarding as needed pain medication and wound care, and the facility failed to follow the plan of care for a resident assessed to be incontinent for 2 of 2 residents in a stage two	F0282	Same as F 279All residents have the potential to be affected. Care plans have been reviewed for all residents with participation of all care givers to identify needs/concerns/problems in an effort to have a complete and accurate POC for each resident. Changes in MD orders are	09/26/2011

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	sample of 25. (#26) (#69) Findings include: 1. The record for Resident #69 was reviewed on 09/14/11 at 8:50 a.m. Diagnoses included, but were not limited to bipolar disorder, auditory hallucinations, high cholesterol, anxiety, agitation, schizoaffective disorder, uncontrolled diabetes mellitus type II and legally blind in the right eye. An admission Minimum Data Set (MDS) Assessment dated 08/25/11, indicated Resident #69 had severely impaired vision. The MDS indicated Resident #69 was able to recall all three words given in assessment and was oriented to year, month and day of the week. The MDS indicated Resident #69 was frequently incontinent of urine and a toileting program had not been attempted since admission to the facility. The MDS indicated Resident #69 was receiving a diuretic. An admission assessment dated 08/19/11 indicated Resident #69 was not continent of bowel or bladder. The admission assessment indicated this resident required supervision for toileting. An assessment for bowel and bladder training dated 08/19/11 indicated Resident #69, "...Occasionally Incontinent [sic]...Continent of bowel...." A current recapitulation with a current physician's order dated 08/19/11 indicated, "...Furosemide 80 mg [water pill] tablet give 1 tablet orally once a day...."		reviewed daily by DON for problems requiring update on POC for specified residents. MDS coordinator will initiate care plan on admission identifying two problems then gernerate additional from triggered items on MDS. Information from resident interviews is also incorporated in the POC as indicated. All disciplines are responsible. DON monitors updates during review of new MD orders daily and weekly in care plan conferences with the individual residents. Review monthly 3x then quarterly 3x in QA. Completed 9/26/11 and on-going.	

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	A current Medication Administration Record (MAR) dated for September 2011, indicated, Resident #69 received Furosemide 80 mg at 9:00 a.m. everyday 09/01/11 through 09/15/11. A nurses note dated 08/20/11 at 1:00 p.m., indicated Resident #69 wears a brief and was incontinent at times. A nurses note dated 08/24/11 at 12:00 p.m., indicated Resident #69 voided while in the main dining room and was assisted with pericare and changing clothes. A nurses note dated 09/02/11, untimed, indicated Resident #69 has episodes of incontinence. During an observation on 09/12/2011 at 02:06 p.m., Resident #69's pants were wet in the middle of her thighs. Resident #69 was in a bedside chair in her room during an initial interview. During an observation on 09/13/11 at 1:12 p.m., Resident #69 was leaving the dining room walking down the hall with a walker. The back of the resident's shorts were wet over lower buttocks area. A Social Service Progress note dated 09/13/11 at 17:41 (5:41 p.m.) indicated, "Very tearful immediately after lunch...had apparently become incontinent after eating and was quite distraught...." On 09/14/11 at 2:45 p.m., care plans, activity notes and social service notes were requested from the Social Service Director (SSD).			

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Care plans for Resident #69 were provided by the SSD on 09/14/11 at 4:30 p.m.

The most recent care plans for Resident #69 were dated 09/01/11 and were reviewed on 09/15/11 at 12:50 p.m.

The record lacked documentation of an incontinence care plan.

During an interview on 09/15/11 at 10:28 a.m., Resident #69 indicated there was not a toileting schedule. Resident #69 indicated, "I 'm getting a water pill in the evening."

During an interview on 09/15/11 at 12:57 p.m., LPN #5 indicated Resident #69 was not on a toileting program. LPN #5 indicated the staff encouraged the resident to toilet before and after meals. LPN #5 indicated, Resident #69 likes to sit down front and doesn't always wear a brief. LPN #5 indicated Resident #69 gets embarrassed if she has an incontinent episode.

During an interview on 09/15/11 at 2:52 p.m., CNA #3 indicated the resident was admitted to the facility with personal briefs size 2X (extra large) and wore two at a time. CNA #3 indicated Resident #69 goes "a lot" when incontinent. CNA #3 indicated Resident #69 is out of personal briefs; therefore, the facility briefs are being used and do not fit properly. CNA #3 indicated the Director of Nursing (DoN) was informed.

2. Resident #26's record was reviewed on 09/14/11 at 9:25 A.M.. Diagnoses included but were not limited to left above the knee amputation, debility, CVA (cerebrovascular accident), HTN (hypertension), dementia with

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	agitation, and psychosis. A current Minimum Data Set (MDS) dated 05/17/11, indicated resident had a BIM score of 6, did not ambulate, and was totally dependent on staff for locomotion, dressing, eating, toileting, personal hygiene and bed mobility. Resident had ROM (range of motion) limitation on both sides of his upper and lower extremities. A current care plan dated 08/31/11, indicated resident had a Foley catheter, was incontinent of bowel and was dependent for ADL's (activities of daily living), bathing, dressing, and grooming. The care plan also indicated resident had contractures of his left hand and left elbow and a rectal fistula. Interventions for the care of the rectal fistula included, "pericare PRN (as needed)..." Current physicians orders dated 06/04/11, indicated "Algisite M (wound dressing) 4"x 4" dressing...pack fistula w/ (with) calcium alginate. Change once daily and PRN soilage..." Current physician orders dated 08/03/11, indicated "Hydrocodone-APAP (pain medication)5-500 mg (milligrams)...give 1 tablet orally every 8 hours..." Current physician orders dated 06/24/2009, indicated "Acetaminophen (pain medication) 325 mg ... give 2 tablets (650 mg) PO (by mouth) every 4 hours PRN (as needed) pain..." During an observation of pericare on 09/14/11 at 10:40 A.M., with CNA #2, Resident #26 was noted to have had a bowel movement and			

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	some stool was sitting in his rectal fistula. CNA #2 wiped the stool from the resident's buttocks and fistula. The CNA indicated at that time the dressing was "...somewhere in there...[inside the wound]." An interview with CNA #2 on 09/14/11 at 10:55 A.M., indicated she would inform the nurse that the resident had a bowel movement. An interview with CNA #2 on 09/14/11 at 12:15 P.M., indicated she had informed the nurse that Resident #26 had a bowel movement. An interview with LPN #5 on 09/14/11 at 12:20 P.M., indicated CNA #2 had informed her of the resident's bowel movement. She indicated she had not conducted a dressing change of the wound at that time. She indicated it was her "...wound day..." and would be getting to the resident on her rounds. An observation of wound care with LPN #5 on 09/14/11 at 1:45 P.M., indicated resident's rectum and fistula were covered in stool. The packing was not observed in the wound. LPN #5 cleansed the wound and packed it. During the wound care, Resident #26 was yelling out in pain. The resident indicated, "...ouch ouch ouch..my hemorrhoids..." The LPN responded by saying, "[res name] you don't have hemorrhoids, you have a wound...." Resident #26 responded by saying, "what's the difference ... it hurts..." LPN #5 indicated at that time the resident had scheduled pain medication prescribed and it was time for him to receive his next dose. She indicated Resident #26 would receive the pain medication after the treatment was completed.			

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	155711	A. BUILDING 00 B. WING	09/16/2011

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	An interview with LPN #5 on 09/14/11 at 3:15 P.M., indicated there was a long time span between when the resident had a bowel movement when the dressing was changed. She indicated the resident has frequent stools and nursing may need to check on the resident more often. A current undated facility policy titled, "Physicians Orders" provided by the DON on 09/16/11 at 8:30 A.M., indicated the policy is to "... assure all new physician orders are carried out in a correct and timely manner...". The procedure section of the policy does not specify that physicians orders should be carried out as written. A current undated facility policy titled, "Pain Management" provided by the DON on 09/16/11 at 8:30 A.M., indicated "...it is the policy of the facility to identify, assess, treat and manage resident pain....Procedure:... assess the resident...administer prescribed pain medication as ordered..." A current undated facility policy titled, "Incontinence Management" provided by the DON on 09/16/11 at 9:00 A.M., indicated "...policy: to ensure that all incontinent residents are clean, dry and odor free at all times...Procedure:...toilet incontinent residents at least every two (2) hours, before and after meals and hs (hour of sleep)...monitor voiding times to be able to address need on their schedule..." 3.1-35(g)(2)			

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F0309 SS=G	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interview, the facility failed to ensure residents received appropriate dialysis care, wound care, and pain management for 1 of 2 dialysis residents, and 1 of 5 residents with wounds, and 1 of 5 residents reviewed for pain management in a Stage 2 sample of 25 (Residents #71 and #26). Findings include: 1. The record for Resident #71 was reviewed on 9/15/11 at 12:30 P.M. Current diagnoses included, but were not limited to, nephrectomy, osteomylitis lower spine, HTN (hypertension), DM (diabetes mellitus), left upper extremity fistula. The current recapitulation of physicians	F0309	All residents have the potential to be affected. Pain management assessments are utilized for each resident receiving pain medication. Wound care has been reviewed and treatment revisions done as indicated. Dialysis resident charts have been reviewed to identify dialysis treatment orders. Lab results, pre/past dialysis notes have been requested from dialysis for each dialysis patient. Wound rounds are done weekly by wound nurse and DON. Effectiveness of treatments will be assessed at least monthly for progress and needed revision if indicated. Pain assessments, dialysis orders, wound orders and other physician orders will be reviewed for	09/26/2011

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	orders lacked an order for the resident to go to a dialysis center for dialysis. An order, dated 8/18/11, indicated Resident #71 was to receive Midodrine 10 mg (milligrams) 3 days a week on Tuesday, Thursday, and Saturday before dialysis, which was the only mention of dialysis in the physicians orders. The Nurses Notes indicated Resident #71 went to dialysis on 8/30/11, 9/1/11, 9/8/11, 9/10/11, 9/13/11 and 9/15/11. The record lacked documentation of pre/post dialysis weights, B/Ps, documentation from the dialysis center, or that he had returned from dialysis. During an interview with LPN #4 on 9/16/11 at 10:10 A.M., she indicated the dialysis center had never sent any paper work back with him. 2. Resident #26's record was reviewed on 09/14/11 at 9:25 A.M.. Diagnoses included but were not limited to left above the knee amputation, debility, CVA (cerebrovascular accident), HTN (hypertension), dementia with agitation, and psychosis. A current Minimum Data Set (MDS) dated 05/17/11, indicated resident had a BIM score of 6, did not ambulate, and was totally dependent on staff for locomotion, dressing, eating, toileting, personal hygiene and bed mobility. Resident had ROM (range of motion) limitation on both sides of his upper and lower extremities. A current care plan dated 08/31/11, indicated resident had a Foley catheter, was incontinent of bowel and was dependent for ADL's (activities of daily living), bathing, dressing, and grooming. The care plan also indicated		compliance weekly through audits by DON. Charge nurses are responsible. DON will monitor through documentation audits weekly. Findings will be monitored monthly 3x and then quarterly 3x in QA. Completed 9/26/11 and on-going.	

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	resident had contractures of his left hand and left elbow and a rectal fistula. Interventions for the care of the rectal fistula included, "pericare PRN (as needed)..." Current physicians orders dated 06/04/11, indicated "Algisite M (wound dressing) 4"x 4" dressing...pack fistula w/ (with) calcium alginate. Change once daily and PRN soilage..." Current physician orders dated 08/03/11, indicated "Hydrocodone-APAP (pain medication)5-500 mg (milligrams)...give 1 tablet orally every 8 hours..." Current physician orders dated 06/24/2009, indicated "Acetaminophen (pain medication) 325 mg ... give 2 tablets (650 mg) PO (by mouth) every 4 hours PRN (as needed) pain..." During an observation of pericare on 09/14/11 at 10:40 A.M., with CNA #2, Resident #26 was noted to have had a bowel movement and some stool was sitting in his rectal fistula. CNA #2 wiped the stool from the resident's buttocks and fistula. The CNA indicated at that time the dressing was "...somewhere in there...[inside the wound]." An interview with CNA #2 on 09/14/11 at 10:55 A.M., indicated she would inform the nurse that the resident had a bowel movement. A pain assessment dated 12/8/10, indicated, "...Resident is capable of reporting presence or absence of pain..." No check marked. "...Resident reports presence of pain..." Yes check marked. "...Resident exhibits behaviors indicative of pain..." No check marked...The			

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	assessment has a hand written note on the bottom of the page signed by the DON dated 06/08/11 that indicated, "...no c/o (complaints of) or evidence of a pain/assessment...." An interview with CNA #2 on 09/14/11 at 12:15 P.M., indicated she had informed the nurse that Resident #26 had a bowel movement. An interview with LPN #5 on 09/14/11 at 12:20 P.M., indicated CNA #2 had informed her of the resident's bowel movement. She indicated she had not conducted a dressing change of the wound at that time. She indicated it was her "...wound day..." and would be getting to the resident on her rounds. An observation of wound care with LPN #5 on 09/14/11 at 1:45 P.M., indicated resident's rectum and fistula were covered in stool. The packing was not observed in the wound. LPN #5 cleansed the wound and packed it. During the wound care, Resident #26 was yelling out in pain. The resident indicated, "...ouch ouch ouch..my hemorrhoids..." The LPN responded by saying, "[res name] you don't have hemorrhoids, you have a wound...." Resident #26 responded by saying, "what's the difference ... it hurts..." LPN #5 indicated at that time the resident had scheduled pain medication prescribed and it was time for him to receive his next dose. She indicated Resident #26 would receive the pain medication after the treatment was completed. An interview with LPN #5 on 09/14/11 at 3:15 P.M., indicated there was a long time span between when the resident had a bowel			

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	movement when the dressing was changed. She indicated the resident has frequent stools and nursing may need to check on the resident more often. A current undated facility policy titled, "Physicians Orders" provided by the DON on 09/16/11 at 8:30 A.M., indicated the policy is to "... assure all new physician orders are carried out in a correct and timely manner...". The procedure section of the policy does not specify that physicians orders should be carried out as written. A current undated facility policy titled, "Pain Management" provided by the DON on 09/16/11 at 8:30 A.M., indicated "...it is the policy of the facility to identify, assess, treat and manage resident pain....Procedure:... assess the resident...administer prescribed pain medication as ordered..." A current undated facility policy titled, "Dialysis" provided by the DON on 09/16/11 at 8:30 A.M., indicated, "Policy: to provide access for the dialysis resident to receive treatment as ordered by the dialysis center...all recommendations from the dialysis site for corrective actions will be addressed....weights will be obtained before and after the dialysis session and recorded..." 3.1-37(a)			

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F0322 SS=D	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. Based on observation, record review and interview, the facility failed to ensure water flushes were done according to facility policy for 1 of 1 G/T (gastrostomy) observation of a water flush in a Stage 2 sample of 25 (Resident #30, QMA #6). Findings include: The record for Resident #30 was reviewed on 9 /14/11 at 9:05 A.M. Current diagnoses included, but were not limited to, traumatic subdural hematoma, schizophrenia, atony of bladder, MR (mental retardation). HTN (hypertension), constipation, hypothyroidism, dyslipidemia, CAD (coronary artery disease). The current recapitulation of physician's orders indicated Resident #30 was to receive 100 ml (milliliters) of water as a flush through the G/T 3 times a day. During the medication administration observation on 9/14/11 at 9:30 A.M., QMA #6 indicated she needed to flush Resident #30's G/T. QMA #6 measured 100 ml of Water in a graduated container. After handwashing and gloving, QMA #6 placed a stethoscope on the residents abdomen and listened. She then	F0322	All residents have the potential to be affected. The QMA has been re-trained on G-tube flushes. Compliance will be monitored by charge nurse during the med pass. Charge nurses are responsible for assuring the QMA is proficient in the procedure. DON will monitor at least one G-tube flush weekly as well as the proficiency of the QMA. Findings will be reviewed monthly 3x and quarterly 3x in QA. Re-training will be done as needed to ensure accuracy of procedure. Completed 9/26/11 and on-going.	09/26/2011

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pulled 30 ml of water up into an asepto syringe, placed it into the end of the G/T and plunged the water down the tube. The rest (70 ml) of the water was allowed to flow into the tube by gravity. Air had not been plunged through the syringe as QMA #6 listened to the abdomen, nor had stomach content been aspirated.

During a conference with the Executive Director and Director of Nursing (DON) on 9/14/11 at 4:45 P.M., the DON indicated this was not how it should have been done.

A current facility policy, dated 7/20/10, provided by the DON on 9/15/11 at 9:05 A.M., titled "Administering medication via G or J (Jejunostomy) tube" indicated:

"...6> check for placement using a stethoscope to identify bowel sounds as you aspirate from the tube. Measure residual by aspirating with the asepto
7. flush the tube per order. Allow to flow by gravity..."

The record for Resident #30 was reviewed on 9 /14/11 at 9:05 A.M.

Current diagnoses included, but were not limited to, traumatic subdural hematoma, schizophrenia, atony of bladder, MR (mental retardation). HTN (hypertension), constipation, hypothyroidism, dyslipidemia, CAD (coronary artery disease).

The current recapitulation of physician's orders indicated Resident #30 was to receive 100 ml (milliliters) of water as a flush through the G/T 3 times a day.

The record for Resident #30 was reviewed on

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	9 /14/11 at 9:05 A.M. Current diagnoses included, but were not limited to, traumatic subdural hematoma, schizophrenia, atony of bladder, MR (mental retardation). HTN (hypertension), constipation, hypothyroidism, dyslipidemia, CAD (coronary artery disease). The current recapitulation of physician's orders indicated Resident #30 was to receive 100 ml (milliliters) of water as a flush through the G/T 3 times a day. 3.1-44(a)(2)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview the facility failed to serve food in a sanitary manner by a cook touching laminated resident meal cards with a gloved hand and then plating food for lunch without changing gloves which had the potential to effect 43 of 43 residents who receive meals from the facility kitchen. (Cook #1) Findings include: During a lunch observation on 09/12/11 at 12:00 p.m., Cook #1	F0371	All residents have the potential to be affected. Policy and Procedure on food handling reviewed by Dietician. All kitchen staff in-serviced on proper food storage, preparation, and serve technique and procedure on 9/21/11. One on One re-training completed for kitchen staff lacking observable skill set in sanitary food service procedures. Dietary Manager and Charge cooks are responsible for monitoring. Errors will be immediately corrected and identified for re-training. Findings will be reviewed with	09/21/2011

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	donned gloves and started plating food using serving scoops and serving ladles. Cook #1 handled laminated resident meal cards. Cook #1 proceeded to serve a lemon wedge on resident plates with the same gloved hands. Cook #1 wiped forehead with the back of the gloved left hand. Cook #1 continued to serve lemon wedge with the same gloved hands. Cook #1 removed a slice of cornbread from a resident's plate in the service line before served and placed the slice of cornbread back into the serving pile. Cook #1 continued to use the same gloves to plate and serve food. During an interview on 09/15/11 at 1:00 p.m., the Dietary Manager (DM) indicated Cook #1 should not have touched laminated meal cards and resident food with the same gloved hands. The DM had several laminated meal cards in her hand during this interview on the unit at the nurse's station. On 09/15/11 at 5:30 p.m. a facility kitchen policy on food handling was requested from the Director of Nursing and the Executive Director. On 09/16/11 at 8:30 a.m. no facility kitchen policy was provided.		Dietician and QA monthly 3x and quarterly 3x. Completed 9/21/11 and on-going.	

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	3.1-21(i)(2)			
F0458 SS=E	Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. Based record review, interview and observation, the facility failed to ensure resident bedrooms measured at least 80 square feet per resident for 6 of 28 rooms. The deficient practice had the potential to affect 12 of 12 residents who resided in these rooms. (Room # 19, 20, 22, 25, 26 and 27). Findings include: A review of the facility's "Bed Inventory Sheet", dated 9/12/11, indicated rooms numbered 19, 20, 22, 25, 26 and 27 were listed as certified Medicaid (NF) Rooms. During the entrance tour on 9/12/11 at 8:30 A.M., it was observed rooms 19, 20, 22, 25, 26 and 27 lacked 80 square feet	F0458	This facility request a room size waiver for rooms #19,20,22,25,26,27.	09/19/2011

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	(sq. ft.) per resident. All identified bed contained two beds. During an interview with the Administrator at that time, he indicated nothing had changed and the rooms were still being utilized the same way. Review of facility measurements for resident rooms numbers 19, 20, 22, 25, 26 and 27, indicated the bedrooms lacked 80 sq. ft. per resident. All identified rooms contained two beds. Room number, number of beds, total square feet per room and square feet per bed were as follows: *19 - 2, 153.38 sq. ft., 76.69 sq. ft. *20 - 2, 142.46 sq. ft., 71.23 sq. ft. *22 - 2, 142.09 sq. ft., 71.05 sq. ft. *25 - 2, 157.01 sq. ft., 78.51 sq. ft. *26 - 2, 145.93 sq. ft., 72.97 sq. ft. *27 - 2, 154.65 sq. ft., 77.33 sq. ft. 3.1-19(1) 3.1-19(2) 3.1-19(3) 3.1-19(4) 3.1-19(8)			

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F0498 SS=G	The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Based on observation and record review, the facility failed to ensure a certified nurses aide (CNA) followed proper procedure and techniques while providing pericare to a dependent resident. This affected 1 of 1 residents observed for pericare in a stage 2 sample of 25. (Resident #26) Findings include: Resident #26's record was reviewed on 09/14/11 at 9:25 A.M.. Diagnoses included but were not limited to left above the knee amputation, debility, CVA (stroke), HTN (hypertension), dementia with agitation, and psychosis. A current Minimum Data Set (MDS) dated 05/17/11, indicated resident #26 had a BIMS (brief interview for mental status) score of 6 (severe cognitive impairment), did not ambulate, and was totally dependent on staff for locomotion, dressing, eating, toileting, personal hygiene and bed mobility. Resident #26 had ROM (range of motion) limitation on both sides of his upper and lower extremities. A current care plan dated 08/31/11, indicated resident #26 had a Foley catheter, was incontinent of bowel and was dependent for ADL's (activities of daily living), bathing, dressing, and grooming. The care plan also indicated resident #26 had contractures of his left hand and left elbow and a rectal fistula.	F0498	All residents have the potential to be affected. A skills check for CNAs has been completed for all CNAs to identify additional training needs. Care in-services are conducted for CNAs at least monthly. Skills check will be conducted at least monthly. Charge nurses are responsible. DON will monitor on daily walking rounds and review of check list. Findings will be reviewed monthly 3x and then quarterly 3x in QA. Completed 9/26/11 and on-going.	09/26/2011

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	155711	A. BUILDING 00 B. WING	09/16/2011

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	During an observation of pericare on 09/14/11 at 10:40 A.M., CNA #2, pulled the covers off of Resident #26. Resident was nude under the covers. CNA #2 roughly grabbed the resident's testicles and started roughly washing them using a wet soapy washcloth. Resident #26's testicles were very red and excoriated. As CNA #2 washed the testicles, the resident started yelling, "...ouch your hurting my balls...stop...that hurts." CNA #2 responded by saying, "sorry, but I gotta clean this". The CNA then grabbed Resident #26's penis and again started roughly washing the penis and the Foley catheter. The resident yelled out, " stop... ouch your hurting my peter...ouch!". The CNA again responded by saying "sorry, I have got to clean this". The CNA did not stop rubbing the resident nor did she reduce the amount of force she was using when the resident stated he was in pain. CNA #2 then rolled Resident #26 over. The resident had a bowel movement and some stool was sitting in his rectal fistula. His buttocks were excoriated. CNA #2 used a dry towel and started wiping Resident #26's buttocks and rectal area. The resident started yelling, "ouch that hurts...you know I have hemorrhoids stop..ouch...ouch...my hemorrhoids!". CNA #2 responded by saying, "you don't have hemorrhoids you have a wound..." There was stool visible in the rectal fistula. Again, the CNA did not reduce the amount of rubbing or the amount of force she was using when the resident stated he was in pain. The CNA turned the resident over on to his back. He was completely exposed. The resident stated, "I'm cold, cover me up." The CNA stated, "Ill cover you up when I'm finished with you." The CNA repositioned Resident #26 and then grabbed a washcloth to place in his contracted left hand. CNA #2			

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	told the resident to relax and started to push the washcloth into the resident's hand. The resident began to yell, "you are killing me....ouch ouch ouch ouch...stop.... you are killing me...stop!" The CNA told the resident if he relaxed it wouldn't hurt as much as she continued to push the washcloth into his hand. The resident yelled again, "...stop...you know I have 'thritis (arthritis)...ouch ouch..." The resident tried to reach up with his other hand and stop the CNA but could not reach her. The CNA did not stop until the washcloth was in his hand. The resident indicated his hand hurt, and the CNA responded, "its going to hurt for a little bit." The CNA left the resident nude and then covered the resident up and left the room. An interview with CNA #2 on 09/14/11 at 10:55 A.M., indicated she was going to go back into the room to put some cream on his testicles. She indicated that she would inform the nurse that the resident had a bowel movement. An interview with CNA #2 on 09/14/11 at 12:15 P.M., indicated she had put cream on the resident's testicles. The CNA indicated, the resident always screams like that during pericare. She indicated, "...I just tell him to relax, like I did when I was putting the washcloth in his hand..." The record lacked documentation of how the resident tolerated perineal care. A CNA skills checklist provided by the DON on 09/16/11 at 8:30 A.M., indicated CNA's are to demonstrate satisfactory skills in pericare, and in bathing dependent residents. A current undated facility policy titled,			

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	"Perineal Care" provided by the DON on 09/16/11 at 8:30 A.M., indicated, "Steps in the procedure....12. Fold the sheet down to the lower part of the body. Cover the upper torso with a sheet...13. Raise the gown or lower the pajamas. Avoid unnecessary exposure of the resident's body...18. For a male resident...wash perineal area starting with urethra and working outward...d. Gently dry perineum following same sequence...Reporting and Documentation...the following information should be reported to the staff/charge nurse and should be documented in the resident's medical record...4. Any discharge, odor, bleeding, skin irritation, complaints of pain or discomfort...5. Problem noted at the urethral-catheter junction during perineal care such as drainage, redness, bleeding, irritation, crusting or pain...6. How the resident tolerated the procedure or any changes in the resident's ability to tolerate or participate in the procedure..." 3.1-14(i)			

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